(CHEP) hospitals are included in the calculation of the ceilings in V.A. 1 through 8, above, but are exempt from the application of these ceilings. For hospitals participating in the Florida Medicaid Program that are located out of State, the FPLI used shall be equal to 1.00.

B. Setting Reimbursement Ceilings for Fixed Cost

1. Compute the fixed costs per diem rate for each hospital by dividing the Medicaid depreciation by the total Medicaid days.
2. Calculate the fixed cost ceiling for each hospital by multiplying Step 1 by 80%. This fixed cost ceiling shall not apply to rural hospitals and specialized psychiatric hospitals.

C. Setting Individual Hospital Rates.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:
   a. To reflect the results of desk reviews or audits;
   b. To exclude from the allowable cost any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.
2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 (1998).
3. Determine allowable Medicaid variable costs as in V.A.3.
4. Adjust allowable Medicaid variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30 or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the latest available projections as of March 31 or September 30 for the DRI National and Regional Hospital Input Price Index as detailed in Appendix A.
5. The variable cost per diem shall be the lessor of:

a. The inflated allowable Medicaid variable costs divided by the sum of Medicaid inpatient days plus Medicaid non-concurrent nursery days for the hospital, or

b. The facility specific target ceiling that is the prior January's rate semester variable cost per diem plus an annually adjusted factor using the DRI inflation table. Effective July 1, 1995, the DRI inflation factor is 3.47 percent. With the adjustment of this DRI factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year. The facility specific target ceiling shall apply to all hospitals except rural, specialized , statutory teaching and Community Hospital Education Program (CHEP) hospitals.

6. a. Establish the variable costs component of the per diem as the lower of the result of Step 5 or the reimbursement ceiling determined under V.A.8. for the county in which the hospital is located.

b. A temporary exemption from the county ceiling for a period not to exceed 12 months shall be granted to an in-state general hospital by AHCA if all of the following criteria are met:

(1) The hospital has been voluntarily disenrolled for a period of not less than 180 days in the 365 days immediately prior to the date of application for this exemption. The hospital shall have been a fully participating Medicaid provider prior to their last disenrollment;

(2) During the 6-month period prior to the last voluntary disenrollment, the hospital provided the largest proportionate share of Medicaid services of all hospitals in the county, as measured by total Medicaid costs for the period;

(3) On the date of the last voluntary disenrollment, less than 51 percent of the private, non-governmental hospitals in the county were participating in the Medicaid Program;

(4) During the 6-month period prior to the last voluntary disenrollment, the hospital treated over 50 percent of the indigent patients in the county who required hospital services during that time period. Indigent patients are those eligible for Medicaid or classified as indigent by a county-approved social services or welfare program.

If an exemption is granted to a hospital, the hospital shall agree to remain in the Medicaid Program and accept Medicaid eligible patients for a period of not less than 3 years from the date of re-enrollment. The exemption shall be granted to a hospital only once since original construction, regardless of changes in ownership or control. If a hospital disenrolls prior to the fulfillment of its 3-year enrollment agreement, AHCA shall recoup funds paid to the hospital in excess of the amount that would have been paid if the county ceiling had been

imposed during the first 12 months which shall be defined as excess amount, according to the following schedule. If a hospital is re-enrolled under the ceiling exemption provision for less than 12 months, the Agency shall recoup 100 percent of the excess amount. For each month of enrollment subsequent to the first year of re-enrollment under the ceiling exemption provision, 1/24 of the excess amount shall be no longer owed so that after 36 months of re enrollment the Department shall recoup none of the excess amount. Example 1: Hospital reenrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on November 30, 1984. During this 5-month period the hospital receives an excess amount of $10,000. Recoupment would be calculated as:

$10,000 - ((0 months x 1/24) x (10,000)) = $10,000

Example 2: Hospital re-enrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on December 31, 1986. During the first 12 months the hospital receives an excess amount of $20,000. Recoupment would be calculated as:

$20,000 - ((18 months x 1/24) x (20,000)) = $ 5,000

7. Compute the fixed costs component of the per diem by dividing the Medicaid depreciation by the total Medicaid days.
8. Established the fixed costs component of the per diem as the lower of Step 7 or the reimbursement ceiling determined under V.B.2.
9. Calculate the overall per diem by adding the results of Steps 6 and 8.
10. Set the per diem rate for the hospital as the lower of the result of Step 9 or the result of inflated Medicaid charges divided by total Medicaid days.
11. For hospitals with less than 200 total Medicaid patient days, or less than 20 Medicaid patient admissions, the per diem rate shall be computed

using the principles outlined in Steps 1 through 10 above, but total costs, charges, and days shall be utilized, instead of the Medicaid apportioned costs, charges and days.

D. Determination of Individual Hospital Regular Disproportionate Share Payments for Disproportionate Share Hospitals (DSH).

1. In order to qualify for reimbursement, a hospital shall meet either of the minimum federal requirements specified in Section 1923 of the Act. The Act specifies that hospitals must meet one of the following requirements:

   a. The Medicaid inpatient utilization rate is greater than one standard deviation above the statewide mean, or;

   b. The low-income utilization rate is at least 25%.

2. Also, a hospital shall qualify for reimbursement if its total Medicaid days when combined with its total charity care days equals or exceeds 7 percent of its total adjusted patient days, and its total charity care days weighted by 4.5 plus total Medicaid days weighted by 1 is equal to or greater than 10 percent of total adjusted patient days, or if all the requirements in Section E.1. a-h are satisfied.

3. Additionally, the Act specifies that in order for the hospital to qualify for reimbursement, the hospital must have at least two obstetricians or physicians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. This does not apply to hospitals where:

   a. The inpatients are predominantly individuals under 18 years of age, or

   b. Non-emergency obstetric services were not offered as of December 21, 1987.

4. a. The hospital Medicaid inpatient utilization rate in 1.a. above shall be calculated once a year based on cost reports used for the July 1 rate setting.

   b. The low-income utilization rate in 1.b. above shall also be calculated once a year every July 1.

5. Payments earned from having a disproportionate share hospital status shall be in addition to each hospital's base Medicaid per diem rate and shall be capped at 170 percent of their total cost per diem rate. All hospitals that qualify for disproportionate share status shall receive a minimum payment, as calculated based on the formula described in Section V.D.

6. Effective July 1, 2000, the Agency shall use the 1992-1993 DSH formula, the 1994 audited data, and the Medicaid per diem rate as of January 1, 1999 to calculate the Hospital Regular Disproportionate Share program payments under section V.D. of the Plan.

7. The total of all disproportionate share payments shall not exceed the amount appropriated, or the federal government's upper payment limits.

8. Hospitals that qualify for a disproportionate share payment solely under V.D.1. (a) or (b), above, shall have their payment calculated in accordance with the following formula:

   TAA = TA x (1/5.5)

   DSHP = (HMD/TSMD) x TAA

   where:

   TAA = total amount available.

   TA = total appropriation.

   DSHP = disproportionate share hospital payment.

   HMD = hospital Medicaid days.

TSMD = total state Medicaid days.

9. The following formula shall be utilized for hospitals that qualify under V. D.2, to determine the maximum disproportionate share rate used to increase a qualified hospital's Medicaid per diem rate:

DSR = ((CCD/APD) x 4.5) + (MD/APD)

Where:

DSR = disproportionate share rate.

CCD = charity care days(as defined in Section X.H.).

APD = adjusted patient days (as defined in Section X.B.)

MD = Medicaid days.

10. For fiscal years 1992-1993, 1993-1994, 1994-1995, 1995-96 and subsequent state fiscal years, the following criteria shall be used in determining the disproportionate share percentage:

a. If the disproportionate share rate is less than 10 percent, the disproportionate share percentage is zero and there is no additional payment.

b. If the disproportionate share rate is greater than or equal to 10 percent, but less than 20 percent, then the disproportionate share percentage is 1.8478498.

c. If the disproportionate share rate is greater than or equal to 20 percent, but less than 30 percent, then the disproportionate share percentage is 3.4145488.

d. If the disproportionate share rate is greater than or equal to 30 percent, but less than 40 percent, then the disproportionate share percentage is 6.3095734.

e. If the disproportionate share rate is greater than or equal to 40 percent, but less than 50 percent, then the disproportionate share percentage is 11.6591440.

f. If the disproportionate share rate is greater than or equal to 50 percent, but less than 60 percent, then the disproportionate share percentage is 73.5642254.

g. If the disproportionate share rate is greater than or equal to 60 percent, but less than 72.5 percent, then the disproportionate share percentage is 135.9356391.

h. If the disproportionate share rate is greater than or equal to 72.5 percent, then the disproportionate share percentage is 170.00.

11. To calculate the total amount earned by all hospitals under this section, hospitals with a disproportionate share rate less than 50 percent shall divide their Medicaid days by four, and hospitals with a disproportionate share rate greater than or equal to 50 percent and with greater than 40,000 Medicaid days shall multiply their Medicaid days by 1.5, and the following formula shall be used by the agency to calculate the total amount earned by all hospitals under this section:

TAE = BMPD X MD X DSP

Where:

TAE = total amount earned

BMPD = base Medicaid per diem

MD = Medicaid days

DSP = disproportionate share percentage

In no case shall total payments to a hospital under this section, with the exception of state facilities, exceed the total amount of uncompensated charity care of the hospital, as determined by the agency according to

the most recent calendar year audited data available at the beginning of each state fiscal year.

12. In calculating regular disproportionate share payments for state fiscal year 1991-1992 only, for those hospitals with more than 30,000 Medicaid days in their 1988 audited Medicaid cost report, the agency shall add 28 points to the disproportionate share percentage for those hospitals with a disproportionate share rate greater than 60 percent and 5.5 points to the disproportionate share percentage for those hospitals with a disproportionate share rate greater than 50 percent but less than 60 percent.

For fiscal year 1991-1992 only, the following criteria shall be used in determining the disproportionate share percentage:

a. If the disproportionate share rate is less than 10 percent, the disproportionate share percentage is zero and there is no additional payment.

b. If the disproportionate share rate is greater than or equal to 10 percent, but less than 20 percent, then the disproportionate share percentage is 2.1544347.

c. If the disproportionate share rate is greater than or equal to 20 percent, but less than 30 percent, then the disproportionate share percentage is 4.6415888766.

d. If the disproportionate share rate is greater than or equal to 30 percent, but less than 40 percent, then the disproportionate share percentage is 10.0000001388.

e. If the disproportionate share rate is greater than or equal to 40 percent, but less than 50 percent, then the disproportionate share percentage is 21.544347299.

f. If the disproportionate share rate is greater than or equal to 50 percent, but less than 60 percent, then the disproportionate share percentage is 46.41588941.

g. If the disproportionate share rate is greater than or equal to 60 percent, then the disproportionate share percentage is 100.

13. The following formula shall be used to calculate the total amount earned by all hospitals under this subsection:

TAE = BMPD x MD x DSP

where:

TAE = total amount earned

BMPD = base Medicaid per diem.

MD = Medicaid days.

DSP = disproportionate share percentage.

14. If the total amount earned by all hospitals is not equal to the amount appropriated, and the amount appropriated is greater than $152,143,583, then adjust each hospital's share on a pro rata basis so that the total dollars paid equal the amount appropriated, not to exceed the federal government's upper payment limits. If the total amount appropriated for fiscal year 1993-1994 only, is less than $152,143,583, then calculate each hospital's share at an appropriation level of $152,143,583 and then reduce all hospitals' shares on a pro rata basis to equal the actual amount appropriated.

15. The total amount calculated to be distributed shall be made in quarterly payments subsequent to each quarter during the fiscal year.

16. Payments to each disproportionate share hospital as determined in Step 12 above shall result in payments of at least the minimum payment

adjustment specified in the Act. The Act specifies that the payment adjustment must at a minimum provide either:

a. An additional payment amount equal to the product of the hospital's Medicaid operating cost payment times the hospital's disproportionate share adjustment percentage in accordance with Section 1886(d)(5)(F)(iv) of the Social Security Act, or

b. A minimum specified additional payment amount (or increased percentage amount) and for an increase in such payment amount in proportion to the percentage by which the hospital's Medicaid utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate for hospital's receiving Medicaid payments in the state.

E. Determination of an outlier adjustment in Medicaid payment amounts for Disproportionate Share Hospitals for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age. Exceptionally high costs are costs attributable to critically ill and/or extremely small (low birth weight) individuals who receive services in Neonatal Intensive Care Units (NICU) of hospitals that qualify for outlier payment adjustments. Exceptionally long lengths of stay are stays in excess of forty-five days.

1. Disproportionate Share Hospitals that qualify under V.D., above, for regular disproportionate share hospital payments and meet all of the following requirements shall qualify for an outlier adjustment in payment amounts.

a. Agree to conform to all agency requirements to assure high quality in the provision of service, including criteria adopted by Department of Health rule 10J-7.003, F.A.C., concerning

staffing ratios, medical records, standards of care, equipment, space and such other standards and criteria as specified by this rule.

b. Agree to provide information to the agency, in a form and manner to be prescribed by rule 10J-7.002(7), F.A.C., of the Department of Health, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

c. Agree to accept all patients for neonatal intensive care and high-risk maternity care, regardless of ability to pay, on a functional space-available basis.

d. Agree to develop arrangements with other maternity and neonatal care providers in the hospital's region for the appropriate receipt and transfer of patients in need of specialized maternity and neonatal intensive care services.

e. Agree to establish and provide a developmental evaluation and services program for certain high-risk neonates, as prescribed and defined by rule of the department.

f. Agree to sponsor a program of continuing education in perinatal care for health care professionals within the region of the hospital, as specified by rule.

g. Agree to provide backup and referral services to the department's county public health units and other low income perinatal providers within the hospital's region, including the development of written agreements between these organizations and the hospital.

h. Agree to arrange for transportation for high-risk obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

2. Hospitals that fail to comply with any of the above conditions, or the rules of the department under Chapter 10J-7, F.A.C., shall not receive any payment under this subsection until full compliance is achieved. A hospital that is non-compliant in two or more consecutive quarters, shall not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating program hospitals.

3. Outlier payment amounts earned by disproportionate share hospitals that meet all of the qualifications in 1.a. through 1.h., above, shall be in addition to each hospital Medicaid per diem rate.

4. The total of all outlier payment adjustments shall not exceed the amount appropriated.

5. The following formula shall be used by the agency to calculate the total amount earned for hospitals that qualify to receive outlier payment adjustments:

TAE = DSR x BMPD x MD

where:

TAE = total amount earned.

DSR = disproportionate share rate.

BMPD = base Medicaid per diem.

MD = Medicaid days.

6. The total additional payment for hospitals that qualify for outlier payment adjustments shall be calculated by the agency as follows:

TAP = (TAE x TA)/STAE

where:

TAP = total additional payment for an outlier facility.

TAE = total amount earned by an outlier facility.

STAE = sum of total amount earned by each hospital that qualifies for outlier payment adjustments.

TA = total appropriation for the outlier payment adjustment program.

7. Distribute the outlier payments in four equal installments during the state fiscal year.

F. Determination of Disproportionate Share Payments for Teaching Hospitals.

1. Disproportionate share payments shall be paid to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. In order to qualify for these payments, a teaching hospital must first qualify for regular disproportionate share hospital payments based on the criteria contained in Section V.D., above.

2. On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the agency shall distribute to each statutory teaching hospital, an amount determined by multiplying one-fourth of the funds appropriated for this purpose times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

a. The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals;

b. The number of full-time equivalent trainees in the hospital, which comprises two components:

(1) The number of trainees enrolled in nationally accredited graduate medical education programs. Full time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

(2) The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the

fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

c. A service index which comprises three components:

(1) The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to services offered by the given hospital, as reported on the Agency for Health Care Administration Worksheet A-2, located in the Budget Review Section of the Division of Health Policy and Cost Control for the last fiscal year reported to the agency before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Service Index values where the total is computed for all state statutory teaching hospitals;

(2) Volume-weighted service index, computed by applying the standard Service Inventory Scores established by AHCA under Rule 59E-5.503 F.A.C., to the volume of each service, expressed in terms of the standard units of measure reported on the Agency

for Health Care Administration Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals;

(3) Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceeding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all statutory teaching hospitals.

3. The following formula shall be utilized by the department to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

TAP = THAF x A

where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

G. Mental Health Disproportionate Share Payments

The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the mental health disproportionate share program:

$$TAP = \left(\frac{DSH}{TDSH}\right) \times TA$$

Where:

TAP = total additional payment for a mental health hospital

DSH = total amount earned by a mental health hospital under s. 409.911

TDSH = sum of total amount earned by each hospital that participates in the mental health hospital disproportionate share program

TA = total appropriation for the mental health disproportionate share program.

In order to receive payments under this section, a hospital must participate in the Florida Title XIX program and must:

a. Agree to serve all individuals referred by the agency who require inpatient psychiatric services, regardless of ability to pay.

b. Be certified or certifiable to be a provider of Title XVIII services.

c. Receive all of its inpatient clients from admissions governed by the Baker Act as specified in chapter 394.

H. Determination of Rural Hospital Disproportionate Share/financial assistance program. In order to receive payments under this section, a hospital must be a rural hospital as defined in s. 395.602, Florida Statutes, and must meet the following additional requirements:

a. Agree to conform to all agency requirements to ensure high quality in the provision of services, including criteria adopted by agency rule concerning staffing ratios, medical records, standards of care,

equipment, space, and such other standards and criteria as the agency deems appropriate as specified by rule.

b. Agree to accept all patients, regardless of ability to pay, on a functional space-available basis.

c. Agree to provide backup and referral services to the county public health units and other low-income providers within the hospital's service area, including the development of written agreements between these organizations and the hospital.

d. For any hospital owned by a county government that is leased to a management company, agree to submit on a quarterly basis a report to the agency, in a format specified by the agency, which provides a specific accounting of how all funds dispersed under this act are spent.

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program or the financial assistance program:

$$TAERH = (CCD + MDD)/TPD$$

Where:

CCD = total charity care-other, plus charity care-Hill Burton, minus 50 percent of unrestricted tax revenue from local governments, and restricted funds for indigent care, divided by gross revenue per adjusted patient day; however, if CCD is less than zero, then zero shall be used for CCD

MDD = Medicaid inpatient days plus Medicaid HMO inpatient days.

TPD = total inpatient days.

TAERH = total amount earned by each rural hospital

In computing the total amount earned by each rural hospital, the agency must use the most recent actual data received by July 1 of each year and reported in accordance with s.408.061(4)(a), Florida Statutes.

(a) In determining the payment amount for each rural hospital under this section, the agency shall first allocate all available state funds by the following formula:

$$DAER = (TAERH \times TARH)/STAERH$$

Where:

DAER = distribution amount for each rural hospital.

STAERH = sum of total amount earned by each rural hospital.

TAERH = total amount earned by each rural hospital.

TARH = total amount appropriated or distributed under this section.

Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share payments under this section.

(b) For state fiscal year 1996-97 and subsequent years, the following steps shall be used to determine the rural disproportionate share payment amount for each hospital.

(1) The agency shall first determine a preliminary payment amount for each rural hospital by allocating all available state funds using the following formula.

$$PDAER=(TAERH \times TARH)/STAERH$$

Where:

PDAER = preliminary distribution amount for each rural hospital.

TAERH = total amount earned by each rural hospital.

TARH = total amount appropriated or distributed under this section.

STAERH = sum of total amount earned by each rural hospital.

(2) Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in section (H)(1) above.

(3) The state funds only payment amount is then calculated for each hospital using the formula:

SFOER = Maximum value of (1)SFOL - PDAER or (2) 0

Where:

SFOER = state funds only payment amount for each rural hospital

SFOL = state funds only payment level, which is set at 4% of TARH.

(4) The adjusted total amount allocated to the rural disproportionate share program shall then be calculated using the following formula:

ATARH = (TARH - SSFOER)

Where:

ATARH = adjusted total amount appropriated or distributed under this section

SSFOER = Sum of the state funds only payment amount (H)(3) for all rural hospitals.

(5) The determination of the amount of rural DSH funds is calculated by the following formula:

TDAERH = ((TAERH x ATARH)/STAERH)

Where:

TDAERH = total distribution amount for each rural hospital.

(6) Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in section (H)(5) above.

(7) State funds only payment amounts (H)(3) are then added to the results of (H)(6) to determine the total distribution amount for each rural hospital.

TDAERH = (TDAERH + SFOER)

I. Determination of Disproportionate Share Payments for Specialty Hospitals

1. The following formula shall be used by the agency to calculate the total amount available for hospitals that participate in the specialty hospital disproportionate share program:

TAE=(MD/TMD) x TA

Where:

TAE=total amount earned by a specialty hospital.

TA=total appropriation for payments to hospitals that qualify under this program.

MD=total Medicaid days for each qualifying hospital.

TMD=total Medicaid days for all hospitals that qualify under this program.

2. In order to receive payments under this section, a hospital must be licensed

in accordance with part I of chapter 395, participate in the Florida Title XIX program, and meet the following requirements:

a. Be certified or certifiable to be a provider of Title XVIII services.

b. Receive all of its inpatient clients through referrals or admissions from county public health departments, as defined in chapter 154.

c. Require a diagnosis for the control of a communicable disease for all admissions for inpatient treatment.

J. Determination of Primary Care Disproportionate Share Payments

1. Disproportionate Share Hospitals that qualify under V.D. above for regular disproportionate share hospital payments and meet all of the following requirements shall qualify for payments under the primary care disproportionate share program.

a. Agree to cooperate with a Medicaid prepaid health plan, if one exists in the community.

b. Agree to ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.

c. Agree to coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level, except that eligibility may be limited to persons who reside within a more limited area, as agreed

to by the agency and the hospital.

d. Agree to contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility, primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours.

e. Agree to cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.

f. Agree to, in cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care program to persons who are not eligible for the Medicaid program, and who reside within the area.

g. Agree to provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do not have private health insurance, regardless of ability to pay, on the basis of available space, except that nothing shall prevent the hospital from establishing bill collection programs based on ability to pay.

h. Agree to work with the Florida Healthy Kids Corporation, the Florida Health Care Purchasing Cooperative, the Florida Health Access Corporation, and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan.

i. Agree to work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate use of health services.

j. Agree to work with the local health council to develop a plan for promoting access to affordable health care services for all persons who reside within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health

insurance generally.

2. Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may not receive payments under this section until compliance is achieved.

3. Hospitals that wish to participate in the primary care disproportionate share program must certify to the agency that they meet the requirements of 1. a.-j. above prior to any qualifying hospital receiving payment under this program.

4. The following formula shall be used to calculate a hospital's disproportionate share factor:

$$DSF = \frac{UIL \times CCD}{TCCD}$$

Where:

DSF=the disproportionate share factor.

UIL=the number of uninsured lives in the qualifying hospital's county.

CCD=audited charity care days per hospital.

TCCD=total audited charity care days for the county.

Note:

a. The number of uninsured lives are based on the uninsured lives per county for 1994 as determined from the 1993 RAND study.

b. The audited charity care days are based on the 1989 charity data used to calculate payments under the regular

disproportionate share program.

5. The following formula shall be used to calculate a hospital's charity care not covered:

$$CCNC = 1 - \frac{RDSHP}{NCC}$$

Where:

CCNC=charity care not covered.

RDSHP=the current regular DSH payment for the qualifying hospital.

NCC=the amount of charity care used for calculating charity care days in the Rural Disproportionate Share Program.

6. The following formula shall be used to calculate the adjusted disproportionate share factor:

$$ADSF = [DSF \times (1+CCNC)],$$
If CCNC<1, then ADSF=DSF

Where:

ADSF=adjusted disproportionate share factor for the qualifying hospital.

7. The following formula shall be used to calculate the total amount earned for each hospital:

$$TAE = TA \times \frac{ADSF}{SASDF}$$

Where:

TAE=total amount earned.

TA=total appropriation.

ADSF=adjusted disproportionate share factor.